April DY5 Reporting – Companion Document

Contents

April Reporting Checklist

Please review this checklist to ensure you have completed all items for April reporting. This checklist is for informational purposes only and does not need to be submitted with April reporting materials.

- ☐ April DY5 Reporting information entered into the online system – "Reporting Status" tab indicates "Ready to Submit" or "Report Submitted" for all sections. (As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.)
- ☐ Semi-annual reporting requirements met:
    - ☐ "Provider Summary Report" completed in the online reporting system.
      For each project:
        - ☐ "Project Summary" tab – all questions answered online for each Category 1 or Category 2 DSRIP project.
        - ☐ "Progress Update" field – completed online for each Category 1 or Category 2 metric and each Category 3 milestone.
- ☐ (If applicable) DY4 Carryforward Reporting information entered into the online system. Carryforward milestones appear with an asterisk on the current year's Project Reporting page.
- ☐ *Coversheet*(s) completed and uploaded. (One *Coversheet* per Category 1 or 2 project - *Coversheets* include boxes for 9 metrics. If a provider is reporting on more than 9 metrics for a given project in DY5, they will need to submit an additional *Coversheet* for that project.)
- ☐ Supporting documentation uploaded to the DSRIP Online Reporting System under "Supporting Attachments" for metrics reporting achievement - file names reference Project IDs, and date ranges that show when the metric was completed are included within each document. (Minimum of 1 supporting document uploaded for each Category 1 or 2 metric, but the same document may be used to demonstrate achievement for multiple metrics if appropriate).
- ☐ *April DY5 QPI Reporting Template* completed and uploaded for DY5 and DY4 Carryforward QPI metrics reporting achievement.
    - ☐ Save as: RHPXX_ProjectID_QPI_AprDY5 (RHP01_123456789.1.1_QPI_ AprDY5)
- ☐ *Category 3 April DY5 Reporting Template* completed and uploaded to report achievement of DY5 and DY4 Carryforward milestones (1 template per provider).
    - ☐ Save as: RHPXX_TPIXXXXXX_Cat3_ AprDY5 (RHP01_123456789_Cat3_ AprDY5)
- ☐ (If applicable) *Category 3 April DY5 Population Focused Priority Measure (PFPM) Reporting Template* completed and uploaded to report achievement of DY5 PM-3.x milestones.
    - ☐ Save as: RHPXX_TPIXXXXXXXX_PFPM_AprilDY5 (RHP01_123456789_PFPM_AprilDY5)
- ☐ (If applicable) *Category 4 Reporting Template* completed and uploaded. (One template per hospital provider participating in Category 4).
    - ☐ Save as: RHPXX_TPIXXXXXX_Cat4_AprDY5 (RHP01_123456789_Cat4_AprDY5)
- ☐ All items listed above submitted through the DSRIP Online Reporting System no later than **11:59 p.m.** on **April 30, 2016.**
- ☐ (If applicable) IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the *IGT Entity Change Form* by **May 27, 2016, 5:00 p.m**. (One IGT Entity Change Form per provider).

Key Points for April 2016 Reporting

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the April DY5 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for DY4 reporting.

Below are several critical points HHSC wants to highlight from the document.

- **Metrics/milestones should only be reported in April if a provider is confident that the metric/milestone was fully achieved by March 31, 2016, and can be clearly demonstrated. For any metric/milestone that HHSC does not find sufficient evidence of achievement in the documentation, the provider will only have one opportunity in June/July to submit additional information. If the provider cannot demonstrate during the June/July "needs more information" (NMI) period that the metric/milestone was completed by March 31, 2016, the provider will no longer be eligible for payment for that metric/milestone.**
    - **Annual metrics** should only be reported in October. More information and examples of these types of metrics can be found on p. 9.
- **All providers are required to provide semi-annual reporting information regardless of whether the provider is reporting achievement of metrics/milestones for payment in April. Future DSRIP payments may be withheld until the complete report is submitted. (p. 6)**
    - The "Provider Summary Report" must be completed by all providers as part of the provider-level Semi-Annual Reporting requirement.
    - For each project, all providers should complete:
        - the "Project Summary" tab – all questions must be answered for each Category 1 or Category 2 DSRIP project.
        - the "Progress Update" field – must be completed for each Category 1 or Category 2 metric and each Category 3 milestone.
- **The reporting deadline is 11:59 p.m. on April 30, 2016, using the DSRIP Online Reporting System: https://dsrip.hhsc.texas.gov/dsrip/login.**
- **Reporting materials (companion documents and reporting templates) can be found on the main HHSC waiver website (http://www.hhsc.state.tx.us/1115-waiver.shtml) on the "Tools and Guidelines for Regional Healthcare Partnership Participants" page under April DY5 Reporting. Please note that separate templates are required for QPI reporting, Category 3 reporting, and Category 4 reporting.**
    - **User Guide for the DSRIP Online Reporting System**
    - **DY3-DY5 Reporting Coversheet**
    - **Learning Collaborative Participation Template –** This template is not required, but includes suggested elements for Lessons Learned documentation for Learning Collaborative metrics.

- **QPI Reporting**
  - **April DY5 QPI Reporting Companion**
  - **April DY5 QPI Template -** Please be sure to download the new QPI Reporting Template from the Waiver website as data has been updated and pre-seeded in the template.
- **Category 3 Reporting**
  - **Category 3 April DY5 Reporting Template**
  - **Category 3 April DY5 Population Focused Priority Measure (PFPM) Reporting Template**
  - **Category 3 April DY5 Reporting FAQ**
- **Category 4 Template**

Please send reporting questions to the HHSC waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us. Please remember to include your RHP, Project ID, and Metric ID when submitting your questions.

Overview

This document includes information on reporting during the first reporting period of DY5 including timelines, DY4 carryforward instructions, use of *Coversheets* and other HHSC reporting templates, QPI guidance, guidance on supporting documentation, and an overview of payment and IGT processing.

For technical instructions on using the DSRIP Online Reporting System, please refer to the *DSRIP Online Reporting System presentation* and *DSRIP Online Reporting System User Guide* posted on the HHSC waiver website on the "Tools and Guidelines for Regional Healthcare Partnership Participants" page under **April DY5 Reporting.** Please note that the reporting system refers to April reporting as Round 1 and October reporting as Round 2.

Supporting documentation submitted in previous reporting periods outside of the DSRIP Online Reporting System (August DY2, October DY2, April DY3, and October DY3 provisional NMI period) is not available on the online reporting system.

As HHSC addresses technical errors with how historical DSRIP payments are shown in the online reporting system, please refer to the payment summaries posted on the HHSC website under Tools and Guidelines for Regional Healthcare Partnership Participants for actual payments made for August DY2 reporting, October DY2 reporting, April DY3 reporting, October DY3 reporting, April DY4 reporting, and October DY4 reporting.

There are two opportunities to report achievement of milestones and metrics in DY5: April and October 2016.

- Milestones and metrics achieved by March 31, 2016, may be reported in April.
- Milestones and metrics achieved by September 30, 2016, may be reported in October.
- The DY4 milestones and metrics approved for carryforward may be reported in April or October of 2016. October 2016 is the final opportunity to report achievement of DY4 carryforward milestones and metrics.
- Changes submitted through the Change Requests (Plan Modification and Technical Change Requests) process in August 2014 for DY4 and DY5 are completed and no further changes will be considered unless requested by HHSC. If there are variations in baselines or previously reported achievement, please address it in reporting as outlined in this companion document under "Guidance for Category 1 and 2 Metrics Reporting" on p. 9.

April Reporting Timeline

- **April 1, 2016** – The DSRIP Online Reporting System will open for providers to begin April DY5 reporting. The templates for *Coversheets*, QPI reporting, Category 3, and Category 4 will be posted to the waiver website as soon as they are available.
    - Some providers have difficulty downloading files from the waiver website using Internet Explorer. We suggest downloading files using Chrome or another browser if possible.
- **April 6, 2016** – HHSC will be holding an April DY5 Reporting Webinar from **10:00–11:30am** which will cover General Reporting, Quantifiable Patient Impact (QPI), and Category 3 guidance.
- **April 22, 2016** – Final date to submit questions regarding April reporting and inform HHSC of any issues with DY5 data in the reporting system.
- **April 30, 2016, 11:59pm**
    - Due date for providers' submission of April DY5 DSRIP reporting using the DSRIP Online Reporting System and upload of applicable *Coversheets*, supporting documentation, and QPI, Category 3 and Category 4 templates. Late submissions will not be accepted.
- **May 1, 2016** – HHSC will begin review of the April reports and supporting documentation.
- **May 12, 2016** - HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved. Final IGT due will be based on HHSC review and approval.
- **May 20, 2016, 5:00pm**
    - Due date for IGT Entities to approve and comment on their affiliated providers' April reported progress on metrics using the "IGT Info" tab for each project. The tab is not an opportunity to identify technical errors entered in the reporting system. Examples of issues to include are reported progress that was not actually achieved, changes in project scope that were not reported by the provider, and risks to the

project that were not reported by the provider. If there are no issues, comments do not need to be submitted and HHSC will assume the IGT Entity has approved the reported information. **If there is a need to identify any technical errors in the reporting system please use the Waiver mailbox to communicate those errors by April 22, 2016, as stated above.**

- **May 27, 2016, 5:00pm** - Due date for submission of any IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the IGT Entity Change Form located at: http://www.hhsc.state.tx.us/1115-docs/092515/IGTEntityChangeForm.xlsx.
- **June 8, 2016** – HHSC and CMS will complete their review and approval of April reports or request additional information (referred to as NMI) regarding the data reported. Note that HHSC completes multiple levels of review prior to determining that a milestone/metric requires additional information.
    - If additional information is requested, the DSRIP payment related to the milestone/metric will not be included with July DSRIP payments.
- **July 1, 2016** – IGT settlement date for April reporting DSRIP payments.
- **July 6, 2016, 11:59pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on April reported Category 1-4 milestone/metric achievement and Semi-Annual Reporting requirements. Please include "NMI" in the file name when uploading documentation in response to NMI requests.
- **July 15, 2016** – April reporting **DY5 DSRIP payments** processed for transferring hospitals and top 14 IGT Entities.
- **July 29, 2016** - April reporting **DY4 DSRIP payments** processed for all providers and **DY5 DSRIP payments** processed for remaining providers that were not paid on July 15, 2016. Note that there are separate transactions for each payment for each DY.
- **August 5, 2016** – HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on April reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for January 2017.

Required Semi-annual Progress Reports

According to the Program Funding and Mechanics Protocol, paragraph 17 (on p. 351 of the waiver amendment approved October 24, 2014), semi-annual progress reports must be submitted to HHSC and CMS. DSRIP payments may be withheld until the complete report is submitted. To meet this requirement, **all providers are required to complete the items below for April DY5 Reporting for every project regardless of whether the milestone/metric is reported for payment in April**. All information will be entered into the online reporting system.

- “Provider Summary Report” - This is a brief overview of your project/s current progress, activities conducted, findings, and outcomes achieved. Providers with multiple projects may submit an executive summary overview of all of their projects in the Provider Summary. Responses should be succinct and provide brief relevant detail.
- For each project:
    - “Project Summary” tab – all questions must be answered for each Category 1 or Category 2 DSRIP project. You may enter “NA” for some of the questions, but there must be an explanation of why the response is “NA” (e.g. NA – no patient impact in DY4 because all project milestones were focused on implementing project. Patient impact will be reported beginning in DY5.)
        - Under “Accomplishments,” describe positive change, forward progression with overall project success (e.g., We have hired a new clinician which will allow us to extend our clinic hours soon.)
        - If there were any variations (difficulties and how they were addressed/plans to address) from the project narrative and metrics that have already been reported as achieved, please provide this information under "Project Overview: Challenges" (e.g., We hired two nurses to meet a DY3 metric, but one of them moved out of the area and we've been unable to refill that position. This may impact our ability to achieve our QPI metrics.).
        - Under “Lessons Learned” describe what worked well, what could be improved, and how it can aid progress (e.g., Incorporating our new patient navigator into the ED team has helped us lower the rate of episodic care in the ED, but we realize that the workload may require additional staff. Patient navigation services could be improved by increasing navigation staff and cultural competency).
        - Under "Patient Impact for Medicaid/Low-Income Uninsured Population," please identify the patient impact in DY4 and specify the Medicaid/low-income uninsured percentage that was served, including the split percentages if available.
        - Under "Progress on Core Components," please list and describe progress on each required core component through September 30, 2015.
        - Under “Continuous Quality Improvement Activities,” if not already described under "Progress on Core Components," describe consistently done actions that are devoted to pushing quality improvement forward (i.e., How the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement).

- "Progress Update" field – **must be completed for each Category 1 or Category 2 metric and each Category 3 milestone**. This should be a succinct summary (one to several sentences as needed), e.g.:
    - (If completed) - Two pediatricians were hired in February 2015 and they have begun to serve patients at the neighborhood clinic.
    - (If in progress) – One pediatrician was hired in December 2014. We continue to advertise for the second pediatrician and hope to have them hired by the end of 2015.
    - (If not completed yet) – We began to advertise to hire the two pediatricians in January 2015. We are interviewing now, but have not yet hired either pediatrician. The goal is to have both of them hired and serving patients by the first quarter of 2016.

DY4 Carryforward Reporting

- Reporting Achievement of DY4 Carryforward Metrics for Category 1-2
    - The carried forward DY4 milestones and metrics are included in the online system under DY5 Round 1 along with the DY5 milestones and metrics and are identified with an asterisk. For Category 1 and 2 carried forward milestones and metrics, please follow the same guidance included in "Guidance for Category 1 and 2 Metrics Reporting" starting on p. 9.
    - Note that if you are reporting on a carried forward percentage improvement metric that is included in the previous DY and the current DY, then the carried forward metric must be demonstrated prior to the current metric. For example, a project includes metric I-10.1 in both DY3 and DY4. Its DY3 goal is a 10% decrease in no-show rates from DY2 baseline and its DY4 goal is a 15% decrease in no-show rates from DY2 baseline. The provider requested carryforward because the DY2 no-show baseline rate was not determined until DY3 - June 2014. To report achievement of the DY3 goal, a minimum of six months of data (July 1, 2014-December 30, 2014 in this example) must be used to demonstrate 10% decrease from the baseline. The DY3 carried forward metric could be reported in April or October 2015. Because this is an annual metric, the DY4 achievement of 15% decrease from the baseline should only be reported in October and use a 12-month period (Oct. 1, 2014-Sept. 30, 2015 in this example). Because this percentage improvement metric is not a QPI metric, the DY4 12-month period may overlap with the period used for reporting DY3 carryforward. Overlapping measurement periods are not allowed for QPI metrics.
- Reporting Achievement of DY4 Carryforward Milestones for Category 3

**Note that the option to carryforward DY5 milestones and metrics will be available in October reporting. Category 3 DY5 achievement milestones (e.g., AM-2.1) that are partially achieved in April reporting may also be carried forward for remaining achievement. See "Category 3: Partial Payment & Carryforward" on p. 33.

Guidance for Category 1 and 2 Metrics Reporting

When determining whether a metric was achieved, HHSC reviews the specific metric description language, baseline/ goal language, numeric goal (if applicable) and data source. HHSC also references the project narrative when clarification of the metric intent or target population is needed. Providers should be sure that the documentation they are submitting in support of a metric is in line with this information and that any information not included in these sources or that requires clarification is included in the supporting documents and/ or *Coversheet*.

Annual Metrics: These metrics require a year's worth of data in order to demonstrate achievement and tend to have percentage goals or include a frequency requirement in the goal language (e.g. attend weekly meetings, produce quarterly reports, etc.). Examples of such metrics can be found below.

Non-QPI Metrics with Percentage Goals: For metrics that include percentage goals, whether a metric may be reported in April depends on the specific metric language and whether the provider can demonstrate by April that the metric was fully achieved for DY5. Examples:

- May be reported in April if achieved by March 31, 2016: Metric P-4.1 (Project Option 1.3.1) - Implement/expand a functional disease management registry. Baseline/Goal: To implement a functional registry in 30% of identified sites as calculated by number of sites with registry functionality out of total number of sites. If the provider has implemented the functional registry in 30% of the identified sites by the end of March, it may report achievement in April.
- May be reported in April if achieved by March 31, 2016: Metric I-11.1 (Project Option 1.1.2) - Patient Satisfaction with primary care services. Goal: Improve patient satisfaction by 10% over baseline as calculated by numerator sum of all survey scores and denominator number of surveys completed. If the provider has improved patient satisfaction by 10% over baseline using the appropriate measure specifications, it may report achievement in April. HHSC isn't prescribing a specific baseline timeframe but each measurement period (baseline and achievement) should be at least six months and the 10% improvement should be demonstrated some time in DY5.

- Should not be reported in April: Metric I-11.1 (Project Option 2.10.1) - Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter. Goal: Provide screening to at least 50% of palliative care patients (319). In this case, metric 1-11.1 is not a QPI metric, so the primary goal is to screen at least 50% of palliative care patients in DY5. Since DY5 will only be halfway completed by March 2016, this metric should be reported in October (or carried forward if needed).
- Should not be reported in April: Metric P-4.1 (Project Option 2.4.1) - Percent of new employees who received patient experience training as part of their new employee orientation. Baseline: 0. Goal: to have 85% of new employees receive patient experience training as part of their new employee orientation. Numerator: Number of new employees receiving patient experience training. Denominator: Total number of new employees. Since DY5 will only be halfway completed by March 2016, this metric should be reported in October (or carried forward if needed).
- Should not be reported in April: "Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions" Metrics. This metric may only be reported in October 2016 or carried forward to DY6 since it is a weekly DY5 metric.

- Other metrics that generally should not be reported in April: Metric I-15.1 *Usual source of care*, Metric I-17.1 *Reminders for patient preventive services* (Project Area 2.1), Metric P-2.3 *Frequency of contact with care navigators for high risk patients* (Project Area 2.9), Metric I-6.2 *Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED* (Project Area 2.9), and Metric I-18.1 *Increase the number of computerized provider order entries* (Project Area 2.11). However, the determination about whether a metric may be reported in April may vary depending on the specific language of the goal or if it is a QPI goal. There may also be other annual metrics that should not be reported in April that have not been given as examples above.

Since a provider will only have two opportunities to demonstrate whether it successfully met a metric (which will be April and June if the provider reports in April), HHSC strongly encourages providers to ask for technical assistance prior to submitting April reporting if you have any questions about whether a metric with a percentage should be reported in April.

Deviation from a Metric: If a provider is deviating from a metric, then an explanation is required in the "Progress Update" field (e.g., Project Area 1.3, Metric P-1.1 requires number of patients entered in the registry; provider requests that metric be met with number of patients

identified in target population to be entered in the registry, not those actually entered). The provider should also reference the progress update information in their *Coversheet*. HHSC will review the request using both the approved project language and the RHP Planning Protocol and submit the request to CMS for approval if deemed appropriate or request additional information. If approved, payment for the requested deviation may be made in the following reporting period depending on approval date (e.g., if a significant variance is requested in April 2016 and HHSC requests additional information, the variance could possibly be approved in June 2016; payment would be made following the October DY5 reporting period, estimated to be in January 2017.) If the requested deviation is not approved after HHSC has requested additional information, the provider will no longer be eligible for payment for that metric.

DY5 Reported Achievement is less than DY4 Reported Achievement: If a provider is reporting on the same metric from DY3 and DY4 but has a lower achievement in DY5, then an explanation should be provided in the "Progress Update" field. For example, the metric goal describes that the provider will demonstrate an 8% improvement in patients' average reported functional status using a standardized instrument (e.g., PROMIS) in DY3 and a 16% improvement in DY4 relative to the average score reported in DY2 (baseline). In DY3 the provider meets (and exceeds) the metric goal by demonstrating 10% improvement in the average score reported. In DY4 provider reports a 3% improvement in average reported score relative to DY2 baseline, demonstrating less of an improvement in DY4 than was recognized in DY3. In "Progress Update" field, provider explains that the smaller improvement in DY4 was due to implementation of an online assessment that was emailed to patients and this resulted in a much lower response rate; whereas in DY3, a paper assessment was administered to patients in the office immediately post-visit, resulting in a higher response rate and potentially creating a respondent bias.

DY2, DY3, or DY4 Reported Achievement has Changed: If the reported and approved achievement of a DY2, DY3 or DY4 metric has changed, please provide an explanation in the Project Summary section under “Project Overview: Challenges” (e.g., Location of DSRIP project has changed from Clinic A to Clinic B due to flooding and water damage at Clinic A. DSRIP services and QPI goals remain unchanged.).

Baseline has Changed: If the baseline reported in DY2 or DY3 has changed, please provide an explanation in the "Progress Update" field for the metric. The stated DY5 goals must still be achieved. If the DY5 goal is an improvement over baseline, HHSC will review in context of the entire project to determine appropriateness.

Metrics with Multiple Parts: All metric goals must be fully achieved to report “Yes-Completed” under “Achieved by March 31” and be eligible for DSRIP payment (e.g., if a goal has two parts of

expanding by 4 hours a week and adding one new exam room, both the expanded hours and new exam room would need to be completed).

General Guidance for Supporting Documentation Used for Multiple Metrics: If the same or similar documentation is used to support multiple metrics, clearly differentiate how each metric was met with similar documentation (e.g., if a metric is using the same curriculum across multiple clinics or for two different chronic care management programs, then demonstrate how different staff were trained on the same curriculum).

Providers Hiring Staff for Multiple Projects: For Categories 1 and 2, providers should not report the same achievement for multiple projects unless it is clear from the approved projects that the overlap makes sense. For example, if a provider reports under two different projects that the provider is hiring one physician and one office manager, the provider should clearly explain if the physician and office manager are the same for both projects and how their time is divided among the projects or if there are two of each. Overlap between projects will be closely reviewed and may not be approved.

Providers Establishing Additional Clinics Providing Multiple Types of Services: For providers establishing additional clinics, expanding existing clinics, or relocating clinics (Project Option 1.1, Milestone P-1), if the clinic will be used for multiple types of services (e.g., OB/GYN and primary care), the provider should clearly explain how the clinic is utilized for the different services. Providers should also be sure to only include data for the type of service that is targeted by their project in their metric calculations.

Early Metric Achievement: DY4 achievement (October 1, 2014 – September 30, 2015) of ***non-QPI metrics*** may be allowable for DY5 metrics, if HHSC deems appropriate (such as if staff were able to be hired early or a clinic opened a little earlier than expected); however, providers also should be aware that early achievement of metrics is a criterion that will be looked at in compliance monitoring. ***QPI metrics*** may not count individuals or encounters in an earlier demonstration year. For example, if a project's QPI goal was 200 in DY4 and 300 in DY5, and the DY4 goal was achieved before the end of DY4, the project could not start counting DY5 achievement until the start of DY5 (October 1, 2015). Early achievement of QPI metrics is not allowed to ensure that projects' impact on patients continues to grow throughout the demonstration period.

Providers Performing Projects in Multiple Regions: If a provider has similar projects in more than one region and the supporting documentation is also the same, then the provider must include an explanation that the documentation is the same, include the other project's(s') applicable IDs for the documentation, and explain how this documentation meets the metric goals for both projects. HHSC will review on a case-by-case basis. This may be allowable for

process metrics when consistent with the approved project. For metrics that report number of patients served, documentation must be provided specific to the patients served in the region.

Reporting on QPI

If a provider is reporting achievement of a DY4 QPI carryforward metric in April for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2014 and March 31, 2016. If a provider is reporting achievement of a DY5 QPI metric in April for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2015 and March 31, 2016. There cannot be an overlap of the demonstration year dates used to count achievement for different years. In other words, once the DY4 QPI carry forward metric is met, counting toward the DY5 metric achievement can begin.

Providers should only submit one *QPI Template* per project per reporting period. The same template is used for DY4 carry forward QPI metrics and DY5 QPI metrics. The template has been updated for April 2016 reporting; a provider that is reporting for DY4 carry forward or DY5 metric achievement must download the April 2016 template from the waiver website so that all project data is properly seeded.

Please read the *QPI Reporting Companion Document* carefully before entering any information and refer to Instructions included in the first tab of the *QPI Template* workbook for general guidance.

Supporting Documentation

Please refer to the RHP Planning Protocols for Categories 1 and 2 and your project specific information for guidance regarding types of supporting documentation and data sources for each metric. The planning protocols are available at the following link: http://www.hhsc.state.tx.us/1115-docs/DSRIP-Protocols.pdf.

General Documentation Guidance:

- Providers must include a *Coversheet* for each project for which they are reporting metric achievement, describing how supporting documents demonstrate achievement of each metric on which they are reporting. The *Coversheet* template is posted on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY5 Reporting.**
    - *Coversheets* include boxes for 9 metrics. If a provider is reporting on more than 9 metrics for a given project in DY5, they will need to submit an additional *Coversheet* for that project.
    - If you are reporting a metric as "No-Partially Achieved" or "No-Not Started", then that metric should NOT be included in the *Coversheet* and supporting

documentation should NOT be submitted for the metric. For these metrics, complete the "Progress Update" field as required by semi-annual reporting.

- Examples of informative coversheets are below:

Metric 1:		
1	Metric ID (e.g., P-1.1):	P-5.1
2	Reporting type (select one):	Reporting current DY (not carryforward)
3	File name(s) for supporting documentation:	123456789.1.1_J.Doe_Provider_Contract_DY4_20150419.pdf 123456789.1.1_J.Smith Contract_DY4_20150419.pdf 123456789.1.1_Primary_Care_Encounter Summary_DY4__20150419.pdf
4	Page #s demonstrating achievement:	For Contracts = Page 1; for Encounters - only one page
5	Describe how the documentation supports achievement of this metric:	123456789.1.1_J.Doe_Provider_Contract_DY4_20150419.pdf - contract on one primary care provider - shows employment as of February 2015. 123456789.1.1_J.Smith Contract_DY4_ 20150419.pdf - contract on second primary care provider - show employment as of November 2014. This provider is actually at a new location for pediatric patients. 123456789.1.1_Primary_Care_Encounter Summary_DY4__20150419.pdf - one page summary table pulled from patient financial system that shows that both providers are not only employed but currently seeing patients in the first six months of DY4. Our goal for this year is to see 40,144 visits by the end of DY4. Through March 2015, we are at 24,629 and expect to achieve our goal by the end of the measurement year.

Metric 2:		
1	Metric ID (e.g., P-1.1):	P-110.1
2	Reporting type (select one):	Reporting current DY (not carryforward)
3	File name(s) for supporting documentation:	RHP3_123456789.2.1_DY3_Agendas RHP3_123456789.2.1_DY3_SLCReporting
4	Page #s demonstrating achievement:	All
5	Describe how the documentation supports achievement of this metric:	The agendas are for each of 20 IDD Crisis Learning Collaborative meetings attended by our Staff. This Learning Collaborative was created in April 2013 and consists of approximately 10 organizations with similar projects across the state. The Learning Collaborative conducted conference calls approximately every two weeks in addition to face to face meetings as scheduled among individual members. The Statewide Learning Collaborative Reporting document shows that our IDD Crisis project Director, Jane Doe attended the face to face statewide RHP Learning Collaboratives on DSRIP projects.

- **All documentation must demonstrate baseline information as well as the increase or total achievement stated in the goal.** For example, a metric includes a baseline of 2 physicians with a DY4 goal of 2 additional physicians, which they met in DY4, and DY5 goal of 1 additional physician providing services. Documentation of DY5 metric achievement must

include identification of the 5 total physicians (the 2 original physicians, the 2 additional physicians hired in DY4 to meet the DY4 goal, and the 1 physician hired to meet the DY5 goal). Hiring documentation must also be included for the 1 physician hired to meet the DY5 goal. The metric may be marked by HHSC as "Needs More Information" if only documentation of 1 new physician is provided. Please see the chart below as an example of what may be submitted to demonstrate baseline. Please refer to the *QPI Reporting Companion Document* for guidance specific to QPI baselines.

Employee Name	Position #	Position Name	FTE	Hire Date	Baseline/Goal Notes
Fran Gomez	1116	Physician	1.00	1/2/2003	Pre-DSRIP
George Powell	1117	Physician	1.00	11/28/2007	Pre-DSRIP
Henry Richards	1118	Physician	1.00	10/28/2014	Hired for DY4 Metric Achievement
Ilene Anderson	1119	Physician	1.00	1/5/2015	Hired for DY4 Metric Achievement
Jennifer Bonds	1120	Physician	1.00	1/15/2016	Hired for DY5 Metric Achievement **See attached contract.**

- If HHSC has provided a response regarding reporting of a milestone/metric, please attach it to the applicable metric when reporting for payment.
- Providers must include dates in supporting documentation to demonstrate achievement occurred by **March 31, 2016** (e.g., date a community assessment was completed, date of hire, date a plan was approved). The date should not just be a date reflecting when the supporting documentation was prepared.
- The related Project ID should be included in the file name of supporting documentation.
- The file name should NOT include special characters (e.g. @, $, #, %, &, etc.) as they create errors when HHSC reviewers are trying to access the files in the reporting system and slow down the review process.
- Providers should submit documentation in common file formats (e.g., pdf, Microsoft Word, Microsoft Excel, Microsoft PowerPoint, zip files).
- Submitting data in an Excel spreadsheet rather than in a document table (e.g., pdf, Word) is strongly encouraged, as this is more conducive to efficient review of your metric. If submitting data in a document, providers should include column totals.
- Documentation should be rotated using landscape and/ or portrait settings as appropriate, so that pages are not upside down or sideways.

- Highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document. Be sure to include page numbers for the relevant information in the *Coversheet*.
- Links will NOT be accepted as supporting documentation.
- Handwritten notes or photos of handwritten notes will NOT be accepted as supporting documentation **(other than for sign-in sheets from meetings).**
- Providers should review supporting documentation carefully to ensure no Protected Health Information (PHI) is included. Additional information on PHI is included in the Warning Notice at the end of this document. Providers should confirm that confidential information is not visible or accessible before submitting documentation to HHSC. If, for example, the provider redacts (i.e., blacks out) information on a document and scans it, they should confirm that information is not visible on the scanned copy. When submitting data in a spreadsheet, providers should be sure that fields containing confidential information are de-identified or deleted. Providers should not rely on hiding columns in a spreadsheet to protect confidential information.
- Sensitive information such as salaries may be redacted.
- Staff names should NOT be redacted (e.g., hiring forms, training logs).

Additional guidance is provided below for many of the most commonly selected milestones and metrics.

- **Non-QPI Metrics Involving Improvement Over Baseline:** HHSC may refer to baseline periods specified in the custom milestone/metric description or "Baseline/Goal" field. If a baseline period is not specified and is cited as a point of improvement for a subsequent goal, a 12-month baseline period should be provided. A minimum six-month baseline period may be allowed due to delayed project implementation with sufficient provider explanation. If a DY5 metric goal is to demonstrate improvement over DY4 performance, there should no gaps in DY4 and DY5 measurement periods without explanation. For example, if intervention activities began in January 2015 and DY5 achievement is being reported, then the baseline measurement period could be January 2015 - September 2015(intervention start to end of DY5) and the DY5 achievement measurement period could be October 1, 2015 – March 31, 2016, and be eligible to report in April of DY5.
- **Percent Improvement Metrics:** In those situations where metric achievement is stated as a percentage increase over prior performance and the language could represent a flat increase in the percentage or an increase relative to prior performance (i.e., X% + prior performance vs. X% * prior performance), HHSC may accept either method of measuring percentage improvement if it is not clearly specified in the baseline/goal language or in the narrative. For example, a 15% improvement may be reported as 50% + 15% = 65% or (50% * 15%) + 50% = 57.5%. Within the reporting coversheet, provider should clarify how these

types of calculations were made and how the calculation aligns with the intention of the goal and where that is supported in the project narrative.

- **Increased Staff Metrics:** For metrics that involve hiring of additional staff to increase care capacity, the goal is that there is an increase in the total number of staff to care for patients due to the DSRIP project and associated funding. HHSC will consider the specific language of the metric and the project when reviewing metrics around increased staff, but the provider should demonstrate as clearly as possible that the staff changes are different than business as usual. For example, business as usual would be "two staff quit on August 31, so we filled those two vacancies within our existing clinic budget." To demonstrate DSRIP achievement, the provider should explain how positions were created or specifically filled to document expansion related to the DSRIP project.
    - Staff must have begun employment by March 31, 2016, and not only signed a contract/agreement to be counted towards increased staff/hiring metrics. (For example, if an employment contract was signed on February 28, 2016, but the physician's start date is April 1, 2016, this metric should wait to report achievement in October 2016.)
    - For Project Area 1.9 projects, mid-level providers may not be counted towards achieving I-22.1 (increase in number of specialist providers) unless they were explicitly stated in the goal as the providers to be hired.
- **Expanded Hours Metrics:** If a goal specifies when the expanded hours are to occur and the expanded hours are changed (e.g., had planned to expand from 5-6 p.m. Monday through Thursday, but instead expanded 5-7 p.m. on Monday and Wednesday), then it will be acceptable as long as the total number of expanded hours remains the same as originally stated and the change makes sense within the context of the project narrative. The documentation must clearly show what the previous hours were (and that they have continued) and that there are additional hours in which appointments are offered.
- **Learning Collaborative Metrics:** For metrics involving learning collaboratives (including regional learning collaboratives), documentation must include the date, agenda, sign in sheet, and a summary of topics discussed and *lessons learned relevant to the project to demonstrate participation.* The provider is not required to make a presentation at the learning collaborative event to demonstrate achievement of the metric. Providers from other regions and non-DSRIP providers may be included in the regional learning collaborative meetings.
    - Statewide Learning Collaborative: Providers who plan to use the Summit to meet metrics related to learning collaborative participation should submit documentation of who from the organization attended or viewed the webcast, what sessions they attended/viewed, what they learned from the event and how they plan to apply the information gained to their DSRIP projects. Please provide information on all

sessions attended or viewed via webcast, with a minimum of ½ day or 3 sessions. HHSC will provide a template you may use, but this is not required. If you do not use the template, please be sure all elements as described here are included.

- **Metrics Involving Meetings:** For metrics involving meetings, all meetings must be scheduled and completed as stated in goals to be eligible for April reporting. Dates, agendas and minutes or summaries of meetings must be submitted as supporting documentation.
- **"Number of new ideas, tools, or solutions, for each idea, tool, or solution" Metrics:** The provider must provide documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken. Another option is to submit a PDSA document for each idea, tool, or solution. A sample template is available on the Institute for Healthcare Improvement (IHI) website at http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. This site does require registration (at no cost). This site is an excellent resource for providers. A provider may continue to test one or more ideas throughout the year; however, activity must occur weekly.
- **"Implement the "raise the floor" improvement initiatives established at the semi-annual meeting" Metrics:** For metrics requiring implementing "raise the floor" improvement initiatives, the documentation should include a list of ideas that came up during the semi-annual meeting that would apply to the project, a description of the provider's agreement to implement at least one idea and rationale for the selection, a description of the status of implementation, and any details related to the impact of the idea on the project (e.g., improvement on project uptake, outcomes, or spread). Providers with similar projects do not need to select the same "raise the floor" initiative.
- **Training metrics:** For metrics that involve training, the documentation should include the training materials and training logs/sign-in sheets. Training logs/sign-in sheets should clearly identify staff being trained, organizations represented, number of people trained, when the training occurred, and where the training took place. For example, stating that "Andy, Mary, and Julie met with Alex and Nancy on the phone to provide diabetes training on 11/2/14" is unclear as to whether 2, 3, or 5 people were trained.
- **Clinical collaborations:** Clinical collaboration agreements being used for supporting documentation should be signed by all parties in order to be accepted for metric achievement.
- **Establishing a plan metrics:**
    - For metrics that require an implementation plan, the following should be included:
        - Roles and responsibilities of those involved in implementation (providers, partner agencies, working group, etc.).
        - Timeline, including:

        - List of tasks to be completed (e.g., development of policies, procedures, or protocols, staff training, steps to address software needs, etc.).
        - Status of each task (e.g., Not started, In progress, Completed).
        - Scheduled start and completion dates for tasks.
        - Actual start and completion dates for tasks.
        - Name(s) of those responsible for completing tasks.
    - For metrics that require an evaluation plan, the following should be addressed:
        - Type of evaluation implementing (e.g., process and/or outcome evaluation).
        - Evaluation questions and measurable outcomes (outputs and outcomes).
        - Resources required (funds, partnerships, staff, technology, survey tools, etc.).
        - Major activities (including timeline and who is responsible).
        - Method for data collection and analysis.
        - Plan for communicating and reporting results.
- **Metrics Involving Disseminating Findings:** If a milestone or metric requires "disseminate findings," if the approved project narrative specified any partnerships or collaborations, the findings should be disseminated to those entities. If the project does not specify any relationships, then the type of information collected would guide to whom the findings should be disseminated. Another option is to disseminate findings with providers with similar projects or reaching similar populations within the RHP.
- **Sample Size:** For milestones or metrics that require a sample size, HHSC suggests use of a sample size calculator like the one available here: http://www.raosoft.com/samplesize.html. Assume a confidence level of 95 percent and margin error of 5 percent.

CATEGORY 1

Project Option: 1.1

Milestone: P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours

Metric P-4.1: Increased number of hours at primary care clinic over baseline.

- Additional Guidance:
    - For expanded hours at existing clinics, provide documentation of previous schedule and new schedule such as brochures or advertisements showing hours before and after expansion, screen shots from a clinic scheduling system clearly showing hours before and after expansion, or other official documents such as letters, memoranda, or meeting minutes describing hours before and after expansion.

- For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.

Milestone: P-5 Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers

Metric P-5.1.: Documentation of increased number of providers and staff and/or clinic sites.

- Additional Guidance:
  - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, position hired for, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
  - For training, provide documentation of who attended training and when.
  - For increased number of primary care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new primary care schedule, etc., as applicable. Also include narrative description in metric reporting or attach separately.

Project Option: 1.2

Milestone: P-2 Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists

Metric P-2.2: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2).

- Additional Guidance:
  - For new primary care faculty members, provide signed contract(s)/letter(s) of position acceptance or other documentation with starting dates and positions.

Milestone: I-11 Increase primary care training and/or rotations.

Metric I-11.7: Improvement in number of primary care practitioners that went on to practice primary care after graduating from primary care training/residency.

- Additional Guidance:
  - HHSC does not consider students practicing in the ER and other hospital-based scenarios to be practicing primary care.

Project Option: 1.9

Milestone: P-11 Launch/expand a specialty care clinic (e.g., pain management clinic)

Metric P-11.1: Establish/expand specialty care clinics.

- Additional Guidance:
    - For additional or expanded specialty care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new specialty care schedule, etc. Also include narrative description in metric reporting or attach separately.
    - For new specialty care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
    - For number of patients served, provide narrative description with data reports to show previous number of patients and expanded number of patients.

Milestone: I-22 Increase the number of specialist providers, for the high impact/most impacted medical specialties

Metric I-22.1: Increase number of specialist providers in targeted specialties

- Additional Guidance:
    - To show an increase in specialist providers, provide documentation such as signed contract(s) or other documentation for new providers and staff with starting dates, new specialty care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
    - Baseline information should be included to show the increase in staff. This could be as simple as a staff roster that includes staff names, position titles, and if they are a part of the baseline or hired as part of the DSRIP project.

Project Option: 1.12

Milestone: P-4 Increase primary care clinic volume of visits and evidence of improved

Metric P-4.1: Number of staff secured and trained

- Additional Guidance:
    - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
    - For training, provide documentation of who attended training and when. Documentation could include training materials such as sign-in sheets (including the dates of the training sessions), presentations, handouts, an HR report showing training sessions and dates, etc.

Milestone: P-6 Establish behavioral health services in new community-based settings in underserved areas.

Metric P-6.1: Number of new community-based settings where behavioral health services are delivered

- Additional Guidance:
    - Please include clear evidence that the settings are new locations for this provider, with documentation such as blueprints or design plans, lease/contract, memorandum of understanding with another provider for use of space, picture of facility with address, new behavioral health schedule or advertisement with new locations listed, floor plans, etc. as applicable.
    - The documentation should clearly show that the number of new community-based settings matches the number of new settings in the goal, and that those settings differ from and are in addition to the providers' previously existing locations. Provider should provide evidence of behavioral health settings utilized prior to DSRIP project implementation for comparison to show that the number of community-based settings has increased.
    - For providers spanning multiple RHPs, the documentation should clearly evidence that the new community-based settings are in the relevant RHP for the project being reported.

Project Option: Multiple (e.g., Project Option 1.7 - Metric P-10.1, Project Option 2.11 - Metric P-9.1)

Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement.

Metric: Description and number of new ideas, practices, tools, or solutions tested by each provider.

- Additional Guidance:
    - This metric is considered an ***annual metric*** should only be reported in Round 2 (October) since data collection would occur throughout the demonstration year on a weekly basis.
    - Documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken should be provided. Another option is to submit a PDSA document for each idea, tool, or solution.
    - Supporting documentation will depend on metric goal language. If the provider mentions a frequency in their goal language, then their documentation should

reflect that. For example, if the goal language states that the provider will be completing quarterly summaries on the number of new ideas, practices, tools, or solutions tested, then those quarterly summaries should be included in the submission.

CATEGORY 2

Project Option: 2.1

Milestone: P-1 Implement the medical home model in primary care clinics.

Metric P-1.1: Increase number of primary care clinics using medical home model.

- Additional Guidance:
  - PCMH recognition is not required under P-1.1 unless stated in the metric goal or project narrative. The provider must show how the medical home model has been implemented (via readiness survey and other documents) and describe the standards that are met as work is continued toward full PCMH recognition. There are several key 'pillars' that represent the medical home model and it would be helpful if these themes are used to describe the steps to implementation, next steps on each theme, and any barriers to implementing fully. The pillars of successful PCMH implementation as well as assessment guides may be found here: http://pcmh.ahrq.gov/sites/default/files/attachments/Strategies%20to%20Put%20Patients%20at%20the%20Center%20of%20Primary%20Care.pdf http://www.coachmedicalhome.org/sites/default/files/coachmedicalhome.org/key-activities-checklist.xls

Milestone: P-11 Identify current utilization rates of preventive services and implement a system to improve rates among targeted population.

Metric P-11.1: Implement a patient registry that captures preventive services utilization.

- Additional Guidance:
  - HHSC does not have a template or a set criterion to be used by providers. However, the registry should be designed to allow for the tracking of patient interactions and clinical studies (e.g. lab reports, patient histories) as necessary and pertinent to the DSRIP project.
  - Helpful references from the American Academy of Family Physicians regarding the development and role of patient disease registries:
    - http://www.aafp.org/fpm/2006/0400/p47.html
    - http://www.aafp.org/practice-management/pcmh/quality-care/patient-reg.html

Project Option: 2.2

Milestone: P-2 Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care.

Metric P-2.1: Increase percent of staff trained

- Additional Guidance:
    - The provider should clearly note how the percentage was calculated in the Goal Calculation field on the milestone/metric's reporting tab.
    - Documentation should be included for both the numerator and denominator. For example, a staff roster could be used to document the denominator, while the numerator could use an HR report showing training sessions and dates.
      Please also include training materials such as sign-in sheets (including the dates of the training sessions), presentations, handouts, etc.

Milestone: P-3 Develop a comprehensive care management program

Metric P-3.2: Increase the number of patients enrolled in a care management program over baseline.

- Additional Guidance:
    - Describe what services are provided in the comprehensive care management program, which patients are eligible, how patients are identified and processes around patient enrollment in the care management program.
    - For number of patients enrolled, provide narrative description with data reports to show baseline number of patients receiving care management services and expanded number of patients receiving care management services. When possible, provide detail around frequency of services used and other relevant trends in utilization. (If this metric is designated as QPI, use the *QPI Template*.)

Project Option: 2.4

Milestone: P-6 Include specific patient and/or employee experience objectives into employee job descriptions and work plans.

Metric P-6.1: % employees who have specific patient and/or employee experience objectives in their job description and/or work plan.

- Additional Guidance:
    - One example of an updated job description may be provided along with either 1) a list of all employees including confirmation that their job descriptions have specific patient and/or employee experience objectives with a date of the updates or 2) other documentation such as an official memo or report stating the number of employees and affirming that all employees' job descriptions have been updated as

of a certain date with a general explanation of what was added to the job descriptions and the process that was followed.
    - It is not necessary to provide all job descriptions, but the job descriptions should be available for audit purposes.

Project Option: 2.7

Milestone: P-1 Development of innovative evidence-based project for targeted population

Metric P-1.1: Document innovational strategy and plan.

- Additional Guidance:
    - Also provide narrative description of how target population was identified, including a description of how evidence based guidelines or interventions have been adapted to fit the target population.

Project Option: 2.11

Milestone: I-8: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease.

Metric I-8.1: X percent increase of patients with chronic disease who receive appropriate disease specific medication management.

- Additional Guidance:
    - "Discharge" is considered a discharge from an acute care setting (typically a hospital) to an outpatient care setting.
    - Medication management instruction documentation would generally include medication schedules or charts in combination with teaching or counseling documentation. Documented activities may include providing and discussing written materials related to medications with patients to ensure that they understand the purpose of various medications, when they should be taken, consequences of drug omission, precautions related to over-the-counter drugs, toxic side effects, etc.

Project Option: 2.13

Milestone: P-2 Design community-based specialized interventions for target populations.

Metric P-2.1: Project plans which are based on evidence / experience and which address the project goals.

- Additional Guidance:
    - In project documentation, provide narrative description of how target population was identified, including a description of how evidence based guidelines or interventions have been adapted to fit the target population.

Milestone: I-5 Functional Status.

Metric I-5.1: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.)

- Additional Guidance:
  - The numerator and denominator used for goal calculation should be included.
  - If this metric is also being used as a QPI metric, then the QPI Template must be submitted along with results of improved functional status.

Project Option: 2.15

Milestone: P-3 Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa

Metric P-3.1: Provide documentation of number and types of referrals that are made between providers at the location.

- Additional Guidance:
  - Also submit standards that were developed and implemented.
  - A referral for a service would count only once during the initial period in which the person was referred. The same person could not be counted towards P-3.1 in subsequent DYs.

Milestone: P-6 Develop integrated behavioral health and primary care services within co-located sites.

Metric P-6.1: Number of providers achieving Level 4 of interaction.

- Additional Guidance:
  - Documentation would need to demonstrate that the client/patient is coming to a single facility and receiving a set of integrated services. This could include a "scheduler" or calendar that shows both primary care and behavioral health providers sharing the same client/patient in the same facility on a shared record (EHR). Documentation could also describe how the providers are interacting. (e.g., case conferences).

Project Option: 2.17

Milestone: I-40 Assessment and Follow-up

Metric I-40.1: Percentage of target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.

- Additional Guidance:

- The numerator and denominator used for goal calculation should be included (i.e. the inpatient population members who have been discharged and those who have received clinician follow-up).
- The provider should include documentation showing which patients received follow up and explain how the provider documented the follow up.

CATEGORY 3

Category 3 Reporting Updates for April DY5

- **All providers must submit a Category 3 template in the April DY5 reporting period**. The Cat 3 April DY5 Template includes progress update fields to meet the requirements of semi-annual reporting. Providers in multiple regions will submit one template per RHP.
- Unlike Category 1 and 2 milestones, beginning in April DY5 **providers will not enter a reporting status, percent of goal achieved, or a progress update into the online reporting system during the primary reporting period for Category 3 milestones PM-10, AM-1.x, AM-2.x, and PM-12.** These milestones will be reported solely in the Category 3 Reporting Template. Providers will be able to review reporting results in the online reporting system after the end of the reporting review period. Providers will still use the online reporting system to report or provide status updates on Category 3 milestones PM-11 (Stretch Activity) and AM-3.x (Population Focused Priority Measure achievement).
- Category 3 outcomes with an approved baseline may report multiple reporting years in one reporting period. Performance year (PY) measurement periods that are completed by 03/31/2016 are eligible to be reported, including PY1, PY2, and PY3 if needed.
- Certain Category 3 outcomes will be eligible to correct baseline or reported performance through the April DY5 measurement period. Eligible outcomes will be able to make corrections, even if performance is not being reported at this time. Correction eligibility will be indicated in the template.
- Please send Category 3 questions related to April DY5 reporting by **Wednesday, April 20th.**
- Category 3 April DY5 Reporting Template: April DY5 Reporting Documents
  - Submitted for reporting of PM-10, AM-1.x, AM-2.x, and PM-12
  - Providers will submit one Category 3 reporting template. The Category 3 reporting template contains all of a provider's projects in one region.
  - Category 3 reporting template should be attached only once to the first Category 3 outcome associated with the first Category 1 or 2 project in the online reporting system.

- Requires certification by Chief Quality Officer or executive responsible for validating the accuracy of Category 3 reporting. The certifier should print out the certification page (summary tab) of the April DY5 reporting template, sign, and upload a copy of the signed certification along with the reporting template.
- Save file as:
  RHPXX_TPIXXXXXXXX_Cat3_AprilDY5 (RHP01_123456789_Cat3_AprilDY5)

- PFPM April DY5 Reporting Template: April DY5 Reporting Documents
  - Submitted for PFPM outcomes with a reported baseline that are eligible to report for achievement in April DY5.
  - Uploaded directly to the Category 3 AM-3.x milestone reporting for achievement. Outcomes not reported AM-3.x in April DY5 will select "no - not started" in the "achieved by March 31st" field.
  - Requires certification by Chief Quality Officer or executive responsible for validating the accuracy of Category 3 reporting.
  - Save file as:
    RHPXX_TPIXXXXXXXX_PFPM_AprilDY5 (RHP01_123456789_PFPM_AprilDY5)

Category 3 Measurement Periods

Performance Years: The term *demonstration year* refers to the October 1 - September 30 divisions within the waiver lifecycle. For Category 3, the term *PY1*, or *performance year one*, refers to the 12 months after a baseline's measurement period. *PY2* refers to the 12 months following PY1 for standard baselines, and the 12 months following baseline for DY4 baselines. *PY3* refers to the 12 months following PY2.

The PY1 measurement period is associated with DY4 milestones PM-10, AM-1.x, and PM-12. The PY2 measurement period is associated with DY5 milestones PM-10, AM-2.x, PM-12, and achievement carried forward from partial achievement of DY4 milestones AM-1.x. PY2 is associated with achievement carried forward from partial achievement of DY5 milestones AM-2.x.

Twelve Month Measurement Periods: All performance measurement periods should be a full twelve months, even if the measure specifications or administration methodology indicate a shorter measurement period. For example, for flu admission rate specifications (IT-2.19), providers would still report a measurement period of 12 months even though the measure specifies reporting on data only during flu season. Providers would report data to measure specifications and report a 12 month measurement period for DSRIP reporting purposes. Similarly, a provider might only administer quality of life surveys (for example, IT-10.1.a.x) one month out of a year as they are reporting on the same population year over year, but should

report their performance measurement period as a full 12 months for DSRIP reporting purposes. Outcomes reporting performance with less than 12 months of data will result in an NMI determination.

Non-Consecutive Performance Measurement Periods: If a provider received approval to report with a proxy population for baseline, the DY4 and DY5 measurement periods may be non-consecutive from the baseline measurement period. For example, if a provider used a comparable clinic to determine a baseline rate for an outcome using a CY2013 measurement period because the DSRIP project clinic was not open until October 1, 2014, the provider may begin their DY4 measurement period on October 1, 2014. Providers reporting with a proxy baseline reporting with a non-consecutive DY4 measurement period should include justification for the non-consecutive measurement period in the April DY5 reporting template in the qualitative field for additional information.

Outcomes not approved to report with a proxy baseline who report a non-consecutive DY4 measurement period without written prior approval from HHSC will result in an NMI determination.

Standard Baseline Measurement Period

Category 3 outcomes are required to submit a baseline with 6 - 12 months of baseline data (with few exceptions), with measurement periods that start as early as 01/01/2012 and end no later than 09/30/2014. Baselines that end by 09/30/2014 (the end of DY3) are considered standard baselines for Category 3 milestone and reporting purposes.

DY4 Baseline Measurement Period

In cases where a provider has no or inadequate data to establish a baseline that ends by 09/30/2014 (the end of DY3), DY4 data may be used to establish a baseline. This results in a change to the Category 3 milestone structure. Outcomes that have been approved by HHSC to report with a DY4 baseline must report a baseline with 12 months of data the 12-month period should be as early as possible and end no later than the end of DY4. If 12 months of data are not available by 09/30/2015 provider may be approved to report all data available through 09/30/2015. If no or insignificant data is available by 09/30/2015 provider will carryforward reporting of PM-10.

Category 3 Milestone Structures

Category 3 milestone structures vary based on whether a baseline measurement period is **standard** (baseline ending by DY3, 9/30/2014) or **DY4,** and whether an outcome is Pay for Reporting (P4R), Pay for Performance (P4P) or Maintenance. The milestone structure assigned to a Category 3 outcome can be confirmed in the Category 3 Summary Workbook as well as the April DY5 Category 3 Reporting Template.

Standard P4P Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY4 Allocation
	AM-1.x*	Achievement of DY4 performance goal	50% of Cat 3 DY4 Allocation
DY5	AM-2.x*	Achievement of DY5 performance goal	100% of Cat 3 DY5 Allocation

Standard P4R Milestone Structure (baseline ending by 09/30/2014)			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications	100% of Cat 3 DY4 Allocation
DY5	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	AM-3.1* *Or* PM-11	Achievement of DY5 performance goal for Population Focused Priority (PFP)measure	50% of Cat 3 DY5 Allocation
		Successful Achievement of Stretch Activity	

Non-Standard P4P Payment Structure - Maintenance Mode			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY4 Allocation
	~~AM-1.x*~~ PM-12	~~Achievement of DY4 performance goal~~ Maintain high performance level	50% of Cat 3 DY4 Allocation
DY5	~~AM-2.x*~~ PM-12	~~Achievement of DY5 performance goal~~ Maintain high performance level	~~100% of Cat 3 DY5 Allocation~~ 50% of Cat 3 DY5 Allocation
	AM-3.1* *Or* PM-11	Achievement of DY5 performance goal for Population Focused Priority (PFP) measure	50% of Cat 3 DY5 Allocation

		Successful Achievement of Stretch Activity 3	

- *Alternate pay for performance measure to be from Cat 3 menu or PFP menu. Baseline is DY3 or DY4. If no alternate measure is possible, SA-3 may be considered.*
  - Providers will maintain statistically significant maintenance of high performance, defined as two proportion z-test with a significance level of .10 (calculator available here: http://www.socscistatistics.com/tests/ztest/Default2.aspx). Providers whose DY4 performance stays above their baseline rate do not need to demonstrate statistically significant maintenance.
  - Providers who do not maintain high performance in DY4 will be eligible to carryforward the DY4 PM-12 milestone for possible achievement in the Category 3 DY5 measurement period.

Non-Standard P4P Milestone Structure - DY4 Baseline (baseline established with DY4 data)			
Year	Milestone	Milestone Description	Payment
DY3	PM-8	Submission of Category 3 DY3 Status Report	50% of Cat 3 DY3 Allocation
	PM-9	Validation and submission of baseline performance *(functions as a status update)*	50% of Cat 3 DY3 Allocation
DY4	PM-10	Successful reporting to approved measure specifications *(functions as a final baseline)*	~~50% of Cat 3 DY4 Allocation~~ 100% of Cat 3 DY4 Allocation
	~~AM-1.x*~~	~~Achievement of DY4 performance goal~~	~~50% of Cat 3 DY4 Allocation~~
DY5	AM-2.x*	Achievement of DY5 performance goal	100% of Cat 3 DY5 Allocation

- *If not already achieved, PM-9 can be achieved by submitting all baseline information collected to date as a status update through. If already achieved, PM-9 doesn't change.*
- *DY4 baseline should be 12 months of data set as early as possible and ending no later than 09/30/2015. If 12 months of data are not available by 09/30/2015 provider may be approved to report all data available through 09/30/2015. If no or insignificant data is available by 09/30/2015 provider will carryforward reporting of PM-10.*
- *DY5 Goal is set as 20% QISMC improvement or 10% IOS improvement over the baseline submitted for PM-10 in DY4.*

Calculating DY4 and DY5 Performance Goals

For those outcomes where the measure type is P4P, DY4 and DY5 performance goals are determined by the reported baseline using one of three standard goal setting approaches described below, based on the selected improvement target. Outcomes with a standard

baseline measurement period will have a DY4 and a DY5 goal. Outcomes with a DY4 baseline will have a DY5 goal only.

Performance goals for P4P outcomes with a Quality Improvement System for Managed Care (QISMC) improvement type are calculated based on where a provider's baseline falls relative to nationally set benchmarks (Minimum Performance Level (MPL) and High Performance Level (HPL)). The Category 3 Compendium includes details on the HPL and MPL for each QISMC P4P outcome measure.

P4P measures where QISMC appropriate benchmarks (HPL and MPL) are not available are designated as Improvement over Self (IOS) measures. In these scenarios, a provider must improve an outcome over the baseline performance.

The table below outlines how performance goals are calculated for P4P measures, excluding survey based outcomes in OD-10 and OD-11.

Improvement Type			DY4 Goal	DY5 Goal
QISMC	Negative Directionality	Below MPL	MPL	MPL - .10(MPL - HPL)
		Between MPL & HPL	Baseline - .10(Baseline - HPL)	Baseline - .20 (Baseline - HPL)
		Above HPL	TA Needed - change to IOS, or maintenance	
	Positive Directionality	Below MPL	MPL	MPL + .10(HPL - MPL)
		Between MPL & HPL	Baseline + .10(HPL - Baseline)	Baseline + .20(HPL - Baseline)
		Above HPL	TA Needed - change to IOS, or maintenance	
IOS	Negative		Baseline - .05(Baseline)	Baseline - .10(Baseline)
	Positive		Baseline + .05(1 - Baseline)	Baseline +.10(1 - Baseline)

The table below shows the performance goals for survey-based P4P measures in ODs 10 and 11. DY4 and DY5 performance goals are set based on scenarios selected by the provider at the time of baseline reporting. In Scenario 1, goals are determined by the change in average pretest and posttest scores observed during the baseline measurement period. In Scenarios 2 and 3, goals are determined by a fixed improvement set relative to the minimum possible score and the maximum possible score for a given survey/tool.

Improvement Type	DY4	DY5

IOS - Survey	Negative	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY4 Posttest Goal= Posttest - .05(Pretest - Posttest)	DY5 Posttest Goal= Posttest - .10(Pretest - Posttest)
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY4 Posttest Goal = Pretest - .05(Max Score - Min Score)	DY5 Posttest Goal: Pretest - .10(Max Score - Min Score)
		Scenario 3 DY3-5 = Average Score	DY4 Average Score Goal: Baseline - .05(Max Score - Min Score)	DY4 Average Score Goal: Baseline - .10(Max Score - Min Score
	Positive	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY4 Posttest Goal= DY3 Posttest + .05(DY3 Posttest - DY3 Pretest)	DY5 Posttest Goal= DY3 Posttest + .10(DY3 Posttest - DY3 Pretest)
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY4 Posttest Goal = DY3 Pretest + .05(Max Score - Min Score)	DY5 Posttest Goal: DY3 Pretest + .10(Max Score - Min Score)
		Scenario 3 DY3-5 = Average Score	DY4 Average Score Goal: DY3 Baseline + .05(Max Score - Min Score)	DY5 Average Score Goal: DY3 Baseline + .10(Max Score - Min Score

Partial Payment & Carryforward

Category 3 P4P outcomes are eligible for partial payment related to percent of goal achieved.

Providers may receive partial payment for making progress towards an eligible P4P outcome improvement target (AM-1.x, AM-2.x). Unearned funds can be carried forward into the next Category 3, 12-month measurement period.

PY1 Goal Achievement Reported	DY4 Payment
100% Achievement of DY4 Goal	100% of funds for AM-1.x in DY4
At least 75 % achievement of DY4 Goal	75% of funds for AM-1.x in DY4
At least 50% achievement of DY4 Goal	50% of funds for AM-1.x in DY4
At least 25% achievement of DY4 Goal	25% of funds for AM-1.x in DY4
Less than 25% achievement of DY4 Goal	No Payment for AM-1.x in DY4

PY2 Goal Achievement Reported	DY5 Payment
Less than 25% achievement of DY4 Goal	*No Payment for AM-1.x in DY5**
At least 25% achievement of DY4 Goal	*25% of funds for AM-1.x in DY5**
At least 50% achievement of DY4 Goal	*50% of funds for AM-1.x in DY5**
At least 75 % achievement of DY4 Goal	*75% of funds for AM-1.x in DY5**
100% Achievement of DY4 Goal	*100% of funds for AM-1.x in DY5**
Less than 25% achievement of DY5 Goal	No Payment for AM-2.x in DY5
At least 25% achievement of DY5 Goal	25% of funds for AM-2.x in DY5
At least 50% achievement of DY5 Goal	50% of funds for AM-2.x in DY5
At least 75 % achievement of DY5 Goal	75% of funds for AM-2.x in DY5
100% Achievement of DY5 Goal	100% of funds for AM-2.x in DY5
*For unachieved portions of DY4 AM-1.x milestones. DY4 and DY5 payments for AM-1.x will not exceed 100% of funds.	

Category 3 goal achievement formulas are determined by the measure directionality (positive or negative) and the baseline measurement period type (Standard of DY4). Goal achievement can be confirmed in the Category 3 Summary Workbook and Goal Calculator, and is automatically calculated in the April DY4 Category 3 Reporting Template. Goal achievement is calculated as follows:

Goal Achievement for P4P Outcomes with Positive Directionality			
PY	Milestone	Standard Baseline	DY4 Baseline
PY1	AM-1.x	(PY1 achieved - baseline)/(PY1 goal - baseline)	NA
PY2	AM-1.x*	(PY2 achieved - baseline)/(PY1 goal - baseline)	NA
	AM-2.x	(PY2 achieved-baseline)/(PY2 goal - baseline)	(PY2 achieved - baseline)/PY2 goal - baseline)
PY3	AM-2.x*	(PY3 achieved - baseline)/(PY2 goal - baseline)	(PY3 achieved - baseline)/(PY2 goal - baseline)

Goal Achievement for P4P Outcomes with Negative Directionality			
PY	Milestone	Standard Baseline	DY4 Baseline
PY1	AM-1.x	(baseline – PY1 achieved)/(baseline – PY1 goal)	NA
PY2	AM-1.x*	(baseline - PY2 achieved)/(baseline - PY1 goal)	NA
	AM-2.x	(baseline - PY2 achieved)/(baseline - PY2 goal)	(baseline – PY2 achieved)/(baseline- PY2 goal)

PY3	AM-2.x*	(Baseline - PY3 achieved)/(Baseline - PY2 goal)	(baseline - PY3 achieved)/(baseline - PY2 goal)

*Carryforward from previous PY if achievement is less than 100%.

Example of goal achievement calculation with Positive Directionality:

Baseline	*.5454*
PY1 Goal	*.5663*
PY2 Goal	*.5872*
PY1 Achievement Reported	*.5550*

AM-1.1 % of goal achieved in PY1 = (PY1 Achieved – Baseline)/(PY1 Goal – Baseline)
(.5550 - .5454)/(.5663 - .5454) = .4593 or 46%

In this example, the provider is eligible to receive 25% of funds associated with this AM-1.1 milestone, and will carryforward the unearned 75% into the DY5 reporting period.

PY2 Achievement Reported	*.5875*

AM-1.1 % of goal achieved in PY2 = (PY2 Achieved – Baseline)/(PY1 Goal – Baseline)
(.5875 - .5454)/(.5663 - .5454) = 2.014 or 201%

AM-2.1 % of goal achieved in PY2 = (PY2 Achieved - baseline)/(PY2 Goal - baseline)
(.5875 - .5454)/(.5872 - .5454) = 1.007 or 101%

In this example, the provider is eligible to receive the additional 75% of unearned funds carried forward from DY4 milestone AM-1.x, and eligible to receive 100% of funds associated DY5 milestone AM-2.1

Providers reporting performance will report the numerator and denominator for their 12-month measurement period in the reporting template. The template will calculate the AM-1.x or AM-2.x percentage of goal achieved.

Carrying forward due to partial achievement does not result in a change to the Category 3 PY1, PY2, or PY3 measurement periods, which are the 12 months immediately following the end of the preceding measurement period.

Carrying forward performance means shifting the unachieved portions of an improvement target to the next 12 month measurement period. Unachieved portions of PY1 goals will be automatically carried forward to be earned in the PY2 measurement period. In DY5, provider

may earn carried forward unearned portions of the DY4 funds, AND earn DY5 funds. Achievement may not be carried forward beyond the 12 months following the measurement period in which initial achievement was less than the goal.

Corrections in the Reporting Template:

In April DY5, the Category 3 Reporting Template will accommodate corrections for both outcomes reporting for achievement and outcomes providing a status update. Most P4P outcomes that have not yet reported performance will be able to make corrections to the reported baseline numerator and denominator through the reporting template. Most P4R outcomes will be able to make corrections to all prior reporting history. P4P outcomes that have already reported performance and some outcomes with custom goal calculation methodology (HHSC Approved Alternate Achievement Request, Maintenance, P4P change to P4R) will not be able to make corrections in the reporting template. Correction eligibility will be included in the April DY5 Category 3 Reporting Template. After the April DY5 reporting period, HHSC will have another Category 3 Interim Correction period for outcomes that have already reported performance or are not eligible to submit corrections through the April DY5 Category 3 Reporting Template.

Stretch Activities (PM-11)

Stretch Activity milestones (PM-11) are only eligible to be reported in October DY5. In April DY5, providers will complete the semiannual reporting progress update fields in the online reporting system for PM-11 milestones.

Population Focused Priority Measures (AM-3.x)

Not Reporting PFPM in April DY5: Outcomes not eligible to report AM-3.x or opting not to report in April DY5 will provide a progress update in the online reporting system and select "No - Not Started" in the "achieved by March 31st" field.

Reporting PFPM in April DY5: Providers with an approved DY3 baseline (baseline ending by 03/31/2016) for their Population Focused Priority Measure (PFPM) milestones (AM-3.x) are eligible to report on performance beginning in April DY5.

PFPM performance should be submitted in the PFPM Performance Template and uploaded directly to the AM-3.x milestone in the online reporting system. Providers should follow instructions for in the PFPM Performance Template when reporting achievement in the online reporting system. PFPM goal calculation and goal achievement will be included in the PFPM template. Additionally, providers should enter these items into the semiannual reporting section, like a Category 1 or 2 milestones, rather than in the Category 3 template.

PFPM Measurement Periods: PFPM Baselines should be a full 12 months and aligned with either DY3 or DY4, with some exceptions confirmed with providers prior to reporting a PFPM baseline. AM-3.x achievement measurement period is the 12 months following the PFPM baseline measurement period. If AM-3.x is not fully achieved in the 12 months following baseline, providers will carryforward partial achievement and be eligible to earn AM-3.x by achieving the AM-3.x goal in the next 12 month measurement period.

PFPM Goal Calculation: Goals for AM-3.x are determined using a standard goal calculation formula determined by the reported baseline. Outcome improvement type is either QISMC or IOS and is pre-determined by the outcome type.

Improvement Type			AM-3.x Achievement Goal
QISMC	Negative Directionality	Below MPL	MPL - .10(MPL - HPL)
		Between MPL & HPL	Baseline - .20 (Baseline - HPL)
		Above HPL	(IOS) Baseline - .10(Baseline)
	Positive Directionality	Below MPL	MPL + .10(HPL - MPL)
		Between MPL & HPL	Baseline + .20(HPL - Baseline)
		Above HPL	(IOS) Baseline +.10(1 - Baseline)
IOS	Negative Directionality		Baseline - .10(Baseline)
	Positive Directionality		Baseline +.10(1 - Baseline)

PFPM Partial Achievement: Category 3 P4P outcomes are eligible for partial payment related to percent of goal achieved. Providers may receive partial payment for making progress towards PFPM improvement target (AM-3.x). Partial payment is available in quartiles, with unearned funds carried forward into the next 12 month measurement period.

AM-3.x Goal Achievement Reported	DY5 Payment
100% Achievement of AM-3.X Goal	100% of funds for AM-1.x in DY5
At least 75 % achievement of AM-3.X Goal	75% of funds for AM-1.x in DY5
At least 50% achievement of AM-3.X Goal	50% of funds for AM-1.x in DY5
At least 25% achievement of AM-3.X Goal	25% of funds for AM-1.x in DY5
Less than 25% achievement of AM-3.X Goal	No Payment for AM-1.x in DY5

Goal achievement formulas are determined by the measure directionality (positive or negative) and are as follows for AM-3.x:

- Positive Directionality: (AM-3.x achieved - baseline)/(AM-3.x goal - baseline)
- Negative Directionality: (Baseline - AM-3.x achieved)/(baseline – AM-3.x Goal)

Supporting Documentation for Category 3 Reporting

Beyond the reporting templates and signed certification page, most providers will not need to submit any additional documentation during the reporting period.

Providers should maintain internal records of the reports used to abstract the numerator and denominator to ensure that the same abstraction method is used across measurement periods, and should HHSC or the compliance monitor ask to see additional details.

All reporting is subject to compliance monitoring. In cases where compliance monitoring determines that actual achievement is less than reported achievement, payments above actual achievement will be recouped.

Providers are required to adhere to measure specifications as outlined in the Category 3 Compendium and maintain a record of any variances that were approved by HHSC prior to reporting baseline. Approval of a reported baseline does not constitute approval to report outside measure specifications. If at any point HHSC or a Compliance Monitor identifies that a provider is reporting a Category 3 outcome outside measure specification, DY4 and DY5 performance reporting payment may be withheld or recouped while the provider works to bring reporting into compliance with Category 3 specifications.

CATEGORY 4

Providers will report DY5 Category 4 Reporting Domains in April 2016 if the measurement periods for a Reporting Domain are complete by March 31, 2016. There is no carry forward for Category 4. Providers who do not meet reporting specifications may be subject to need more information (NMI) requests from HHSC.

Category 4 has six Reporting Domains (RDs), and all RDs should be reported in a single DY5 Category 4 template. **Responses to qualitative questions must be included for all applicable submitted RDs.**

Save file as: *RHPXX_TPIXXXXXXXX_Cat4_AprDY5 (RHP01_123456789_Cat4_AprDY5)*

- RDs 1, 2, & 3:
    - The Institute for Child Health Policy (ICHP), which is Texas' Medicaid External Quality Review Organization (EQRO), prepared reports based on Calendar Year 2014 Medicaid and CHIP data for hospitals for reporting domains RD-1 – Potentially Preventable Admissions, RD-2 – 30-day Readmissions, and RD-3 – Potentially Preventable Complications. HHSC provided the individual reports on RD-1, RD-2, and RD-3 to hospitals by email by April 4, 2016. This data will not be re-sent for October 2016 reporting. If an individual report needs to be re-sent to

a provider, please contact HHSC at TXHealthcareTransformation@hhsc.state.tx.us.
    - The DY5 measurement period is calendar year 2014 and RDs 1-3 may all be reported in April or October 2016.

- RDs 4, 5, & 6:
    - Hospitals will also report the RD-4 – Patient Centered Healthcare, RD – 5 Emergency Department measures, and optional RD – 6 Initial Core Set of Health Care Quality Measures if indicated in the RHP Plan, based on all-payer data submitted by the individual provider.
    - Providers will have the option of reporting RDs 4, 5, and 6 for Medicaid only data, if available. In DY5, providers will report this in a field designated for Medicaid only data.
    - The DY5 measurement period for RDs 4, 5, & 6 are determined by the DY4 measurement period. The DY5 measurement periods will be the 12 months immediately following the end of the measurement period reported in DY4. Providers will be eligible to report RD-4, RD-5, and RD-6 in April 2016 only if their DY5 measurement period ended no later than March 31, 2016. Reporting domains not eligible for reporting in April because of their DY5 measurement period will report in October 2016.
    - **HHSC will not accept measurement periods of less than 12 months.**
    - Providers are not required to submit additional documentation beyond the *Category 4 Reporting Template.* However, providers are subject to additional monitoring at any time and should maintain the documentation for their Category 4 data.

Category 4 Template Instructions

Reporting Domains 1, 2, & 3:

Providers will confirm that they received the relevant reports or that they did not have sufficient eligible admissions/readmissions to receive a given report, and respond to qualitative questions for each reporting domain. **Providers that do not receive a report because of low volume are still required to respond to qualitative questions.**

The EQRO has compiled data reports for Potentially Preventable Admissions/Readmissions/Complications and providers will use this data to populate the qualitative fields within RD-1, RD-2, and RD-3.

- Responses to qualitative questions must be included for all applicable submitted RDs. Example responses below may be brief statements that would need elaboration.

1. **How does the currently documented number of [PPAs, PPRs, or PPCs] represent an increase or a decrease over the last reporting period? What factors have contributed to any increase or decrease?** (e.g., We had a 35% decrease in readmissions from last year and we feel this is due to an increase in patient navigator retention. Patients that were previously frequent readmits are now receiving disease management in outpatient clinics as a result of navigator services.)
2. **How is this information used to inform any changes to your current processes and procedures?** (e.g., We use the data in our quarterly Quality Committee, where leadership from all departments attend as a means of increasing organizational data transparency, demonstrating interdisciplinary collaboration, and supporting discord for evidence-based patient care. As a result, leaders are able to disseminate the information to their staff and exchange feedback on processes and procedures. When necessary, those communications are fielded to the Quality department for collaboration in formal performance improvement.
3. **How does this Medicaid only rate compare to [PPAs, PPRs, or PPCs] rates for your broader population?** (e.g., The Medicaid-only rate is higher than the Non-Medicaid rate because most of the patients we serve are Medicaid; e.g. We are unable to compare due to system limitations; e.g. We estimate that the Medicaid-only rate is lower than the Non-Medicaid rate because our payer mix shows that we served more Non-Medicaid patients).
4. **Do you track PPA/PPC/PPR rates for your broader all-payer population? And if so, what trends are observed?** (e.g., Yes, it seems the [PPA/PPC/PPR] rates are higher for our Medicaid population because most of the patients we serve are Medicaid. The data collected by our quality department and lead patient navigator also seems to suggest the same as many readmissions and complications are Medicaid-derived. Like last year, top likely Medicaid-derived, DRGs were associated with conditions such as CHF, PNE, and COPD. We are hopeful that we can improve patient outcomes with our new outpatient clinic that focuses on internal medicine and the recruitment of a second interventional cardiologist).
5. **If PPAs/PPCs/PPRs are zero, is it because of a low Medicaid service volume, or processes/procedures in place that are effectively addressing potentially preventable events amongst all patient served in your facility?** (e.g., PPAs/PPCs/PPRs are zero/are low because we are a small provider and service a smaller population. When PPAs/PPCs/PPRs are increased during a particular quarter, we review cases with the appropriate performance improvement teams and take action as necessary).
6. **Describe any established processes/policies/procedures in place to identify and**

address PPAs/PPCs/PPRs in your facility.

*****Responses of "NA" should include an explanation. *****

Reporting Domain 4:

Component 1: Patient Satisfaction

For RD-4 Component 1, providers will report the percentage of survey respondents who choose the most positive, or "top-box" response for the following measures, displayed below.

For additional information, visit:
http://www.hcahpsonline.org/Files/HCAHPS_Fact_Sheet_June_2015.pdf

Data is publicly reported and available on Hospital Compare:
https://data.medicare.gov/data/hospital-compare/Patient%20Survey%20Results

- HCAHPS Reporting Measures:
  - Percent of patients who reported that their doctors "Always" communicated well
  - Percent of patients who reported that their nurses "Always" communicated well
  - Percent of patients who reported that they "Always" received help as soon as they wanted
  - Percent of patients who reported that their pain was "Always" well controlled
  - Percent of patients who reported that staff "Always" explained about medicines before giving it to them
  - Percent of patients who reported that YES, they were given information about what to do during their recovery at home.
  - Percent of patients who reported that their room and bathroom were "Always" clean
  - Percent of patients who reported that the area around their room was "Always" quiet at night
  - Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
  - Percent of patients who reported YES, they would definitely recommend the hospital.

HHSC is unable to grant exceptions to the use of HCAHPS unless there is a reason that using HCAHPS would be inappropriate for the population served.

Component 2: Medication Management

For RD-4 Component 2, providers will report on NQF measure 0646. The measure specifications can be found on the NQF website here, and in the Category 4 section of the RHP planning protocol.

If manual chart review is required, please use the following sampling guidelines:

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Instructions to hospitals reporting alternate Medication Reconciliation for RD-4 Component 2
Several hospitals have communicated that they have a comprehensive medication reconciliation process, but it deviates from the NQF 0646 measure because they do not provide patients a list of "do not take" medications on discharge. In these limited cases only, providers may report their medication reconciliation for RD-4 as follows:

- Select "No" in response to the question "Are you reporting in compliance with NQF 0646".
- In the quantitative field, include the numerator, denominator, and resulting rate relevant to your medication reconciliation process.
- In the qualitative field, explain 1) what the quantitative measurement represents; 2) that you have a comprehensive reconciliation process; 3) why you have opted to use this process; and 4) what information you have to show that the process is effective.
- Providers that deviate from NQF 0646 will be subject to compliance monitoring for this measure.

Reporting Domain 5:

RD-5 (Admit decision time to ED departure time for admitted patients) specifications are defined in National Quality Forum Measure 0497. The specifications are available here. Note: "Time" and "Provider Time" in the numerator and denominator are used interchangeably. The numbers entered should be all-payer data. Please also include the ED admit decision time to ED departure time for admitted patients information for DSRIP eligible patients in the qualitative response section if available.

If manual chart review is required, please use the following sampling guidelines.

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Reporting Domain 6:

Providers must report on all of the listed measures; however, for measures that cannot be reported, providers may provide a justification to explain why a measure cannot be reported.

Possible acceptable rationales for not reporting on a measure include:

- The hospital does not serve the population that is being measured.
- The hospital does not provide outpatient services that are being measured.
- There is not a statistically significant population to report the measure – defined as at least 30 cases included in the denominator.
- The hospital's current data systems do not allow for the measure to be reported; if so, include information about what the hospital is doing to be able to report it in later years.
- The identical data is being reported as a Category 3 outcome (including same denominator as Category 3).

Many of the measures are not hospital-focused, and measures marked with an asterisk (*) in the reporting template are only applicable to providers with outpatient services.

Measures marked with a double asterisk (**) have been modified to be specific to DSRIP providers, similarly to the changes made in Category 3 measures (e.g. "member" modified to "patient"). Please see the corresponding Category 3 compendium document for these specifics.

Please see the links below to the technical specifications and resource manuals for detailed measure guidelines.

Child Set of Core Measures

Adult Set of Core Measures

April Payment and IGT Processing

Categories 1 and 2 Payment Calculations

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made and approved within each specific milestone. A milestone may consist of one or more metrics. A Performing Provider must fully achieve a Category 1 or 2 metric to include it in the incentive payment calculation.

Based on the progress reported and approved, each milestone will be categorized as follows:

If consisting of one metric:

- Full achievement (achievement value = 1)
- Less than full achievement (achievement value = 0)

If consisting of more than one metric:

- Full achievement (achievement value = 1)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .5)
- At least 25 percent achievement (achievement value = .25)
- Less than 25 percent achievement (achievement value = 0)

The Performing Provider is eligible to receive an amount of incentive funding for that milestone determined by multiplying the total amount of funding related to that milestone by the reported achievement value. If a Performing Provider has previously reported progress on a milestone with multiple metrics and received partial funding, only the additional amount it is eligible for will be disbursed.

Example of Category 1 or 2 disbursement calculation:

A Category 1 Project in DY 3 is valued at $4 million and has one milestone with two metrics and one milestone with three metrics.

The Performing Provider reports the following progress in April and has been approved by HHSC and CMS:

Milestone 1: 100 percent achievement (Achievement value = 1)

- Metric 1: Fully achieved
- Metric 2: Fully achieved

Milestone 2: 66.7% percent achievement (Achievement value = .5)

- Metric 1: Fully achieved
- Metric 2: Fully achieved
- Metric 3: Not Achieved

Disbursement for April reporting: Milestone 1 ($2 million *1 = $2 million) + Milestone 2 ($2 Million *0.5 = $1 Million) = $3 Million

By the end of the Demonstration Year, the Performing Provider successfully completes all of the remaining metrics for the project. The provider is eligible to receive the balance of incentive payments related to the project:

Disbursement for October reporting is $4 million - $3 million = $1 million.

Note that DSRIP funds are Medicaid incentive payments that are earned for achieving approved metrics at agreed upon values. Once those funds are earned, neither HHSC nor CMS is prescribing how they are to be spent, but we certainly encourage providers to spend them to improve healthcare delivery, particularly for the Medicaid and low-income uninsured populations.

Category 3 Payment Calculations

April DY5 Category 3 payments are based on performance reported in the *April DY5 Category 3 Reporting Template,* completion of the *Category 3 April DY5 Population Focused Priority Measure (PFPM) Reporting Template,* and approval of the submission by HHSC and CMS.

For P4R Category 3 outcomes, 100 percent of DY4 funding is for reporting to approved measure specifications (PM-10).

For process milestones, a Performing Provider must fully achieve to qualify for the DSRIP payment related to these milestones.

For P4P Category 3 outcomes with a standard baseline (using DY3 or prior historical data) and standard achievement type, 50 percent of DY4 funding is for PM-10, reporting to approved measure specifications (process milestone) and 50 percent is for AM-1, achievement of DY4 performance goals (achievement milestone). For outcomes with multiple components/rates the 50% allocation toward achievement (AM-1) is split evenly between the number of components/rates (e.g. AM-1.1 and AM-1.2) and these achievement milestones can be achieved or partially achieved independently.

Example milestone structure for outcomes with a single component/rate

The P4P outcome selected is IT-1.7 Controlling high blood pressure. This outcome has a single component or part with a DY4 value of $200K and DY5 value of $300K the following is a description of the milestone structure and payment allocation by milestone.

- DY4 Milestones
    - PM-10: Successful reporting to specs $100K—carry forward eligible, not eligible for partial payment.

    - AM-1.1: Achievement of DY4 performance goal $100K—partial achievement and carryforward eligible.
- DY5 Milestone
    - AM-2.1: Achievement of DY5 performance goal $300K—partial achievement and carryforward eligible.

Example milestone structure for outcomes with multiple components/rates

P4P outcome selected is IT-4.19 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls. This outcome has 3 components or parts (screening, risk assessment and plan of care) with a DY4 value of $200K and DY5 value of $300K. The following is a description of the milestone structure and payment allocation by milestone.

- DY4 Milestones
    - PM-10 Successful reporting to specs (for all components) $100K—carry forward eligible, not eligible for partial payment.
    - AM-1.1: Achievement of DY4 goal for component 1 (screening)- $33K- partial achievement and carryforward eligible.
    - AM-1.2: Achievement of DY4 goal for component 2 (risk assessment)- $33K- partial achievement and carryforward eligible.
    - AM-1.3: Achievement of DY4 goal for component 3 (plan of care)- $33K- partial achievement and carryforward eligible.
- DY5 Milestones
    - AM-2.1: Achievement of DY5 goal for component 1 (screening)- $100K- partial achievement and carryforward eligible.
    - AM-2.2: Achievement of DY5 goal for component 2 (risk assessment)- $100K- partial achievement and carryforward eligible.
    - AM-2.3: Achievement of DY5 goal for component 3 (plan of care)- $100K- partial achievement available.

For a detailed explanation of **Partial Achievement**, please refer to p. 33-35 under *Category 3: Partial Payment and Carryforward*.

For information regarding **PFPM Partial Achievement**, please refer to p. 37 under *Category 3: Population Focused Priority Measures (AM-3.x)*.

Category 4 Payment Calculations

A hospital Performing Provider will be eligible for a Category 4 DSRIP payment for each Reporting Domain within the *Category 4 Template* completed and approved by HHSC and CMS.

Partial payments do not apply to Category 4.

Approved October 2015 Needs More Information (NMI) milestones and metrics

In March 2016, HHSC completed review of October 2015 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and

metrics will be included in the July 2016 payment processing of April reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

IGT Processing

In June 2016, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for July 2016 payment processing of approved October reports. The IGT amounts for October 2015 approved DY3 or DY4 NMI milestones and metrics, DY4 carry forward achievement, DY5 achievement, and DY5 monitoring will be indicated as well as a total IGT amount.

Per Texas Administrative Code §355.8204, HHSC may collect up to $5 million per demonstration year from DSRIP IGT entities to serve as the non-federal share (50 percent IGT/50 percent federal funds) for DSRIP monitoring contracts. For DY5, HHSC plans to collect $5 million in Monitoring IGT. The monitoring amount for each IGT Entity is a portion of the $5 million based on the January 1, 2016 value of the IGT Entity's funded DY5 Category 1-4 DSRIP projects out of all DY5 Category 1-4 DSRIP projects in the state.

HHSC will request 100 percent of the DY5 IGT monitoring amount with July 2016 payment processing of April reports. If the full DY5 IGT monitoring amount is not submitted by an IGT Entity in July 2016, it will be requested with January 2017 payment processing of October reports.

An IGT Entity may either transfer the total IGT amount due for DSRIP and monitoring or an amount less than the total IGT due. If less than the total IGT amount is transferred, then HHSC will account for the IGT monitoring amount first and the remaining IGT will be proportionately used to fund DY3, DY4 and DY5 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in July, the remaining IGT amount due for its affiliated projects' achievement may be transferred with January 2017 payment processing of October DY5 reports. **July 2016 will be the final opportunity to submit IGT for DY3 achievement.**

DSRIP payments are made using the Federal Medical Assistance Percentage (FMAP) for the federal fiscal year (October 1 – September 30) during which the DSRIP payment is issued and is not based on the demonstration year FMAP of the achieved milestone or metric. The FMAP for FFY2016 and used for July 2016 DSRIP payment processing of April reports is 57.13. The FMAP of 56.18 will be used for January 2017 DSRIP payment processing of October DY5 reports.

IGT Entity Changes

The IGT Entity(ies) and proportion of funding for each project/outcome are listed on the HHSC website on the Tools and Guidelines for Regional Healthcare Partnership Participants page under **April DY5 Reporting**. By May 12, 2016, HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved to inform any needed IGT

changes. Final IGT due will be based on HHSC review and approval. If you have changes to the IGT Entity, either in Entity or proportion of payment among IGT Entities, listed in the reporting system, please complete the *IGT Entity Change Form* available at http://www.hhsc.state.tx.us/1115-docs/092515/IGTEntityChangeForm.xlsx . IGT Entity changes must be received no later than **May 27, 2016, 5:00 p.m.** for April reporting DSRIP payment processing. Any changes received after May 27, 2016, will go into effect for the October DY5 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for April reporting will not impact the remaining IGT monitoring amounts since monitoring contract amounts due for DY5 are based on each IGT entity's proportional share of DY5 Category 1-4 DSRIP projects as of January 1, 2016.

WARNING NOTICE Regarding Submission of Supporting Documentation

All information submitted for DSRIP reporting by Texas Healthcare Transformation and Quality Improvement Program §1115 Waiver participants is subject to the Public Information Act ("Act"), Chapter 552 of the Government Code. Certain information, such as commercial or financial information the disclosure of which would cause significant competitive harm, is excepted from public disclosure according to the Act. If you believe that the documentation submitted through this system is excepted from the Act, please note that belief at the beginning of your submission, including the particular exception you would claim.

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable Client Information. While the DSRIP online reporting system is secure, and access is limited to HHSC program auditors, protected health information (PHI) is not required by HHSC and should not be transmitted. As such, Providers are prohibited from submitting Personally Identifiable Information about clients, HIPAA Protected Health Information or Sensitive Personal Information in connection with submittal of meeting the metric. Providers are required to only submit De-identified information [as evidence of meeting a metric]. If Provider inadvertently uploads individually identifiable client information or following discovery of an Event or Breach, the Provider should report this to HHSC Waiver Staff and the Provider's designated privacy official or legal counsel to determine whether or not this is a privacy breach which requires notice to your patients. HHSC will remove the PHI-containing files as necessary, but requests that providers submit de-identified versions of the original documentation and description of corrective actions for auditing and recordkeeping purposes. Provider will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any event or breach of confidential information to the extent and in the manner determined by HHSC. Provider's obligation begins at the discovery of an event or data breach and continues as long as related activity continues, until all effects of the event are mitigated to HHSC's satisfaction.

Definitions

"**Breach**" means any unauthorized acquisition, access, use, or disclosure of confidential Client Information in a manner not permitted by [this incentive program] or applicable law. Additionally:

(1) HIPAA Breach of PHI. With respect to Protected Health Information ("PHI") pursuant to HIPAA regulations and guidance, any unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Regulations is presumed to be a Breach unless Provider, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Compromise will be determined by a documented Risk Assessment including at least the following factors:

i. The nature and extent of the Confidential Information involved, including the types of identifiers and the likelihood of re-identification of PHI;
ii. The unauthorized person who used or to whom PHI was disclosed;
iii. Whether the Confidential Information was actually acquired or viewed; and
iv. The extent to which the risk to PHI has been mitigated.

With respect to PHI, a "breach," pursuant to HIPAA Breach Regulations and regulatory guidance excludes:

(A) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of HHSC or Provider if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations.

(B) Any inadvertent disclosure by a person who is authorized to access PHI at HHSC or Provider to another person authorized to access PHI at the same HHSC or Provider location, or organized health care arrangement as defined by HIPAA in which HHSC participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations.

(C) A disclosure of PHI where Provider demonstrates a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information, pursuant to HIPAA Breach Regulations and regulatory guidance.

(2) Texas Breach of SPI. Breach means "Breach of System Security," applicable to electronic Sensitive Personal Information (SPI) as defined by the Texas Breach Law. The currently undefined phrase in the Texas Breach Law, "compromises the security, confidentiality, or integrity of sensitive personal information," will be interpreted in HHSC's sole discretion, including without limitation, directing Provider to document a Risk Assessment of any reasonably likelihood of harm or loss to an individual, taking into consideration relevant fact-specific information about the breach, including without limitation, any legal requirements the unauthorized person is subject to regarding confidential Client Information to protect and further safeguard the data from unauthorized use or disclosure, or the receipt of satisfactory assurance from the person that the person agrees to further protect and safeguard, return and/or destroy the data to the satisfaction of HHSC. Breached SPI that is also PHI will be considered a HIPAA breach, to the extent applicable.

(3) Any unauthorized use or disclosure as defined by any other law and any regulations adopted there under regarding Confidential Information.

"Client Information" means Personally Identifiable Information about or concerning recipients of benefits under one or more public assistance programs administered by HHSC.

"De-Identified Information" means health information, as defined in the HIPAA privacy regulations as not Protected Health Information, regarding which there is no reasonable basis to believe that the information can be used to identify an Individual. HHSC has determined that health information is not individually identifiable and there is no reasonable basis to believe that the information can be used to identify an Individual only if:

(1) The following identifiers of the Individual or of relatives, employers, or household members of the individual, are removed from the information:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an Individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers (including without limitation, Medicaid Identification Number);

(I) Health plan beneficiary numbers;

(J) Account numbers;

(K) Certificate/license numbers;

(L) Vehicle identifiers and serial numbers, including license plate numbers;

(M) Device identifiers and serial numbers;

(N) Web Universal Resource Locators (URLs);

(O) Internet Protocol (IP) address numbers;

(P) Biometric identifiers, including finger and voice prints;

(Q) Full face photographic images and any comparable images; and

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and

(2) Neither HHSC nor Provider has actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is a subject of the information."

"Discovery" means the first day on which an Event or Breach becomes known to Provider, or, by exercising reasonable diligence would have been known to Provider and includes Events or

Breaches discovered by or reported to Provider, its officers, directors, partners, employees, agents, work force members, subcontractors or third-parties (such as legal authorities and/or Individuals).

"Encryption" of confidential information means, as described in 45 C.F.R. §164.304, the HIPAA Security Regulations, the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools will be stored on a device or at a location separate from the data they are used to encrypt or decrypt.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH ACT and regulations thereunder including without limitation HIPAA Omnibus Rules, in 45 CFR Parts 160 and 164. Public Law 104-191 (42 U.S.C. §1320d, *et seq*.); Public Law 111-5 (42 U.S.C. §13001 *et. seq.*).

"HIPAA Privacy Regulations" means the HIPAA Privacy Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A, Subpart D and Subpart E.

"HIPAA Security Regulations" means the HIPAA Security Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 Subpart A and Subpart C, and Subpart D.

"HITECH Act" means the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), and regulations adopted under that act.

"Individual" means the subject of confidential information, including without limitation Protected Health Information, and who will include the subject's Legally authorized representative who qualifies under the HIPAA privacy regulation as a Legally authorized representative of the Individual wherein HIPAA defers to Texas law for determination, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3. "Legally authorized representative" of the Individual, as defined by Texas law, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3, includes:

(1) a parent or legal guardian if the Individual is a minor;

(2) a legal guardian if the Individual has been adjudicated incompetent to manage the Individual's personal affairs;

(3) an agent of the Individual authorized under a durable power of attorney for health care;

(4) an attorney ad litem appointed for the Individual;

(5) a guardian ad litem appointed for the Individual;

(6) a personal representative or statutory beneficiary if the Individual is deceased;

(7) an attorney retained by the Individual or by another person listed herein; or

(8) If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate.

"Personally Identifiable Information" or "PII" means information that can be used to uniquely identify, contact, or locate a single Individual or can be used with other sources to uniquely identify a single Individual.

"Protected Health Information" or "PHI" means individually identifiable health information in any form that is created or received by a HIPAA covered entity, and relates to the Individual's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further described and defined in the HIPAA. PHI includes demographic information unless such information is De-identified, as defined above. PHI includes without limitation, electronic PHI, and unsecure PHI. PHI includes PHI of a deceased individual within 50 years of the date of death.

"Unsecured Protected Health Information" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized Persons through the use of a technology or methodology specified by the HITECH Act regulations and HIPAA Security Regulations. Unsecured PHI does not include secure PHI, which is:

(1) Encrypted electronic Protected Health Information; or

(2) Destruction of the media on which the Protected Health Information is stored.